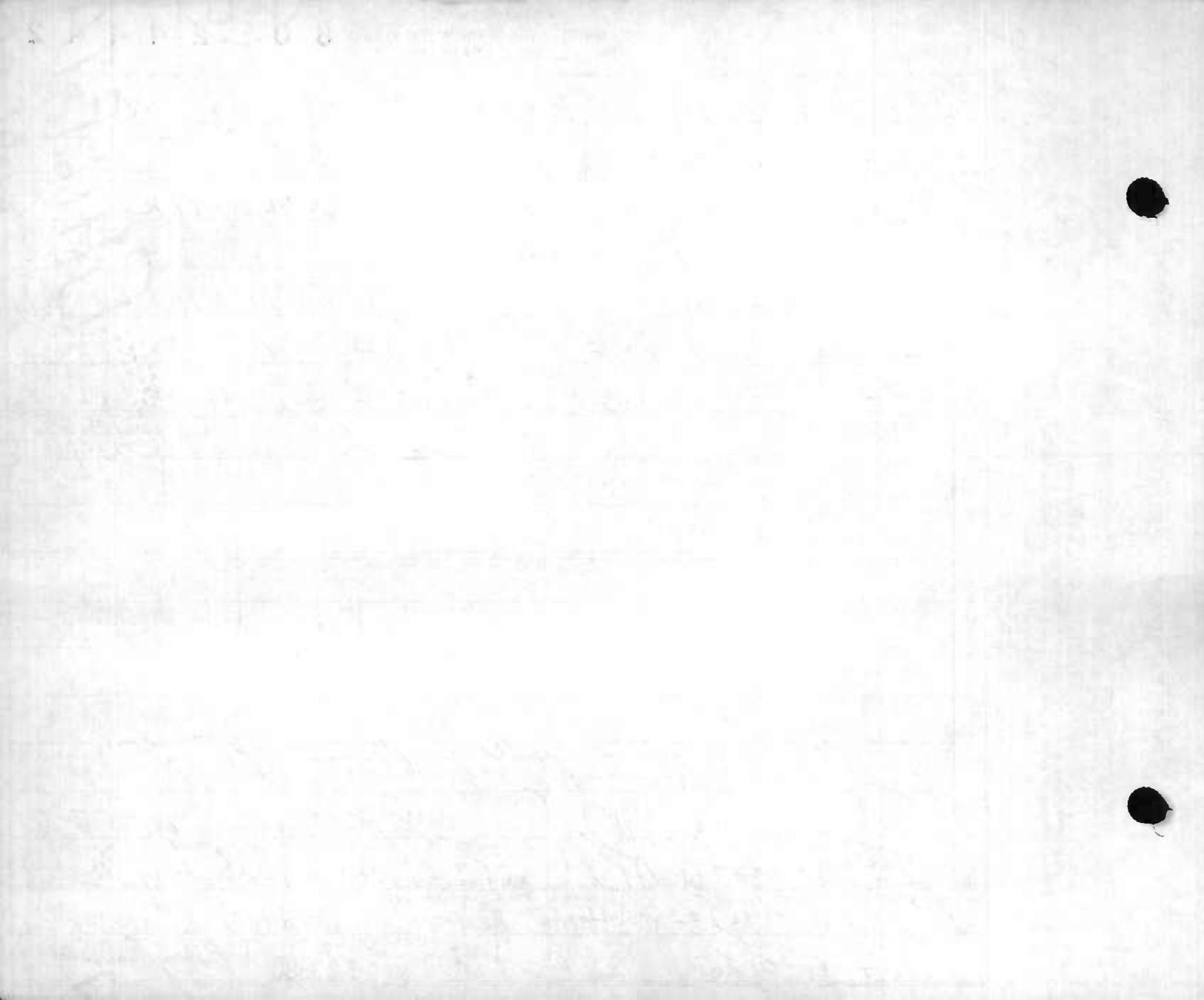


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be given to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 4 4 2			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR			
DORETHA				M		BENNETT		9-8-80		2b. HOUR			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS		IF UNDER 1 YEAR HOURS MIN.					
FEMALE		BLACK		4 7 15		65		YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH					
MD		U.S.A.				WORCESTER		STOCKTON					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
STOCKTON BX 91 STOCKTON, MD										POLITY			
13a. STATE MD										13b. COUNTY Worcester	13c. CITY OR TOWN Stockton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS BX 91 Stockton, MD
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S M AIDEN NAME FIRST MIDDLE LAST									
WALTER C PURNELL				EMMA M Seiby									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
				213-16-8360		James A. Bennett		Stockton MD					
18. CAUSE OF DEATH (Enter only one cause per line for item 18, Part I only) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of Stomach</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>			
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT HOME <input type="checkbox"/> NOT WHILE AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) examined the deceased from <u>8 Sept 80</u> to <u>10 Aug 80</u> , to <u>8 Sept 80</u> , that (I) (we) last saw the deceased alive on <u>19 Aug 80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										22e. DATE SIGNED <u>20 Sept 80</u>			
23. SIGNATURE <u>W. Purnell, M</u>										DEGREE			
24. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. Purnell, M</u>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		9-13-80		Home Beneficial		STOCKTON		Worcester		MD			
24. FUNERAL DIRECTOR NAME <u>West- Farber</u>										25a. DATE REC'D. BY REGISTRAR <u>SEP 22 1980</u>	25b. REGISTRAR'S SIGNATURE <u>John J. Farber</u>		
ADDRESS <u>Salisbury, Md.</u>													



IPC 73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3024443								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR					
George									Bolling Sr.			<input checked="" type="checkbox"/> 9-15 1980			6 PM					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN			9. DATE PRONOUNCED DEAD			10. DATE MONTH DAY YEAR							
MALE	NEGRO	3 14 1910	70 YRS.							9-15 1980			6 PM							
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. CITY OR TOWN OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY					
VA			U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED			Worcester			Snow Hill			LABORER					
13a. STATE			13b. COUNTY			14. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
MD			Worcester			Snow Hill									LABORER					
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
FRANK						MARY			224-05-9728N			ROSA Lee Bolling Sr.			1 HOUR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. ADDRESS			16d. DUE TO, OR AS A CONSEQUENCE OF			16e. DUE TO, OR AS A CONSEQUENCE OF			16f. DUE TO, OR AS A CONSEQUENCE OF					
																		SEVERAL YRS.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) MASSIVE HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) LUNG CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). INANITION																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE			Dorothy C. Holzworth			TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER			DATE SIGNED 9-16-80											
EXAMINER'S NAME (TYPE OR PRINT)			DOROTHY C. HOLZWORTH			ADDRESS 309 TIMMONS ST. SNOW HILL, MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-20-80			23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Mem. Park			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			West Forks			Salisbury					
						SED 18 1980														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

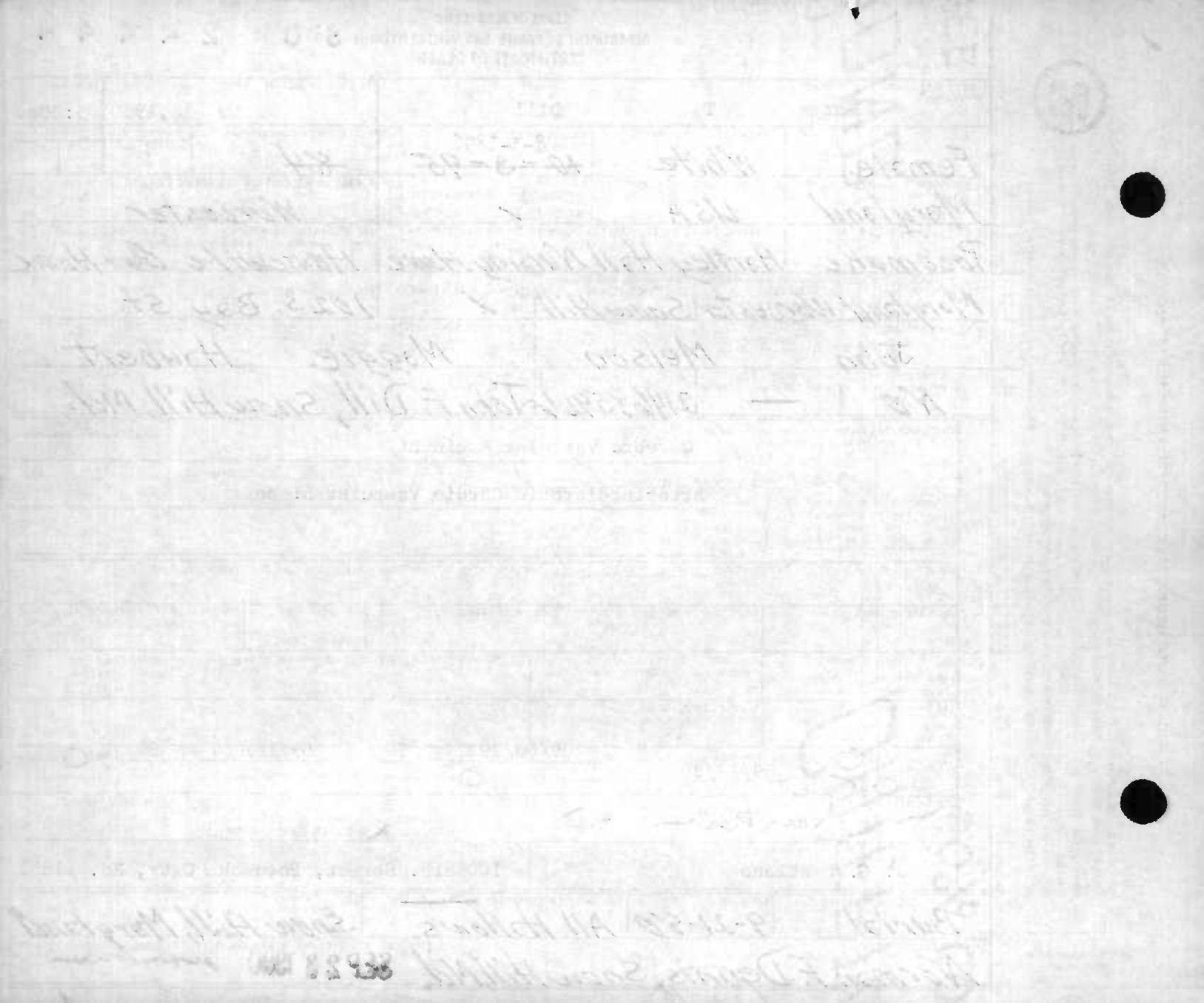
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 5, 6, 7, 547 9/25/80 GS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 24444

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Mary			T	Dill		09	18	1980	5:20am	
3. SEX	4. RACE	5. DATE OF BIRTH MONDAY-3-10-896	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	7. IF UNDER 24 HRS HOURS	8. IF UNDER 24 HRS MIN.		
Female	White	10-9-95		84	83	YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	USA		Worcester							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SURF FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY							
Pocomoke	Hartley Hill Nursing Home	Housewife	Own Home							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS						
Maryland	Worcester	Snow Hill		1025. Bay St.						
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
John				Maggie Haubert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No	2146859100	John F. Dill, Snow Hill, Md.		4292 Cerebro Vascular Accident						
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio Vascular Disease										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (1) this hospital attended the deceased from 09/16/79 1979 to 09/18/1980, that (1) (we) last saw the deceased alive on 09/17/80 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.										
22b. SIGNATURE J. G. Santiano M.D.	DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 100 8th. Street, Pocomoke City, Md. 21851					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. G. Santiano	22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SURNAM)	23b. DATE Burial 9-21-80	23c. NAME OF CEMETERY OR CREMATORIAL All Hallows	23d. LOCATION CITY OR TOWN Snow Hill, Maryland							
24. FUNERAL DIRECTOR NAME Norman F. Dennis, Snow Hill, Md.	ADDRESS	25a. DATE REC'D. BY REGISTRAR SEP 23 1980	25b. REGISTRAR'S SIGNATURE Norman F. Dennis							



TO HOSPITAL OR ATTENDING PHYSICIAN

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

**1 - STATE
REGISTRAR**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 4 4 5

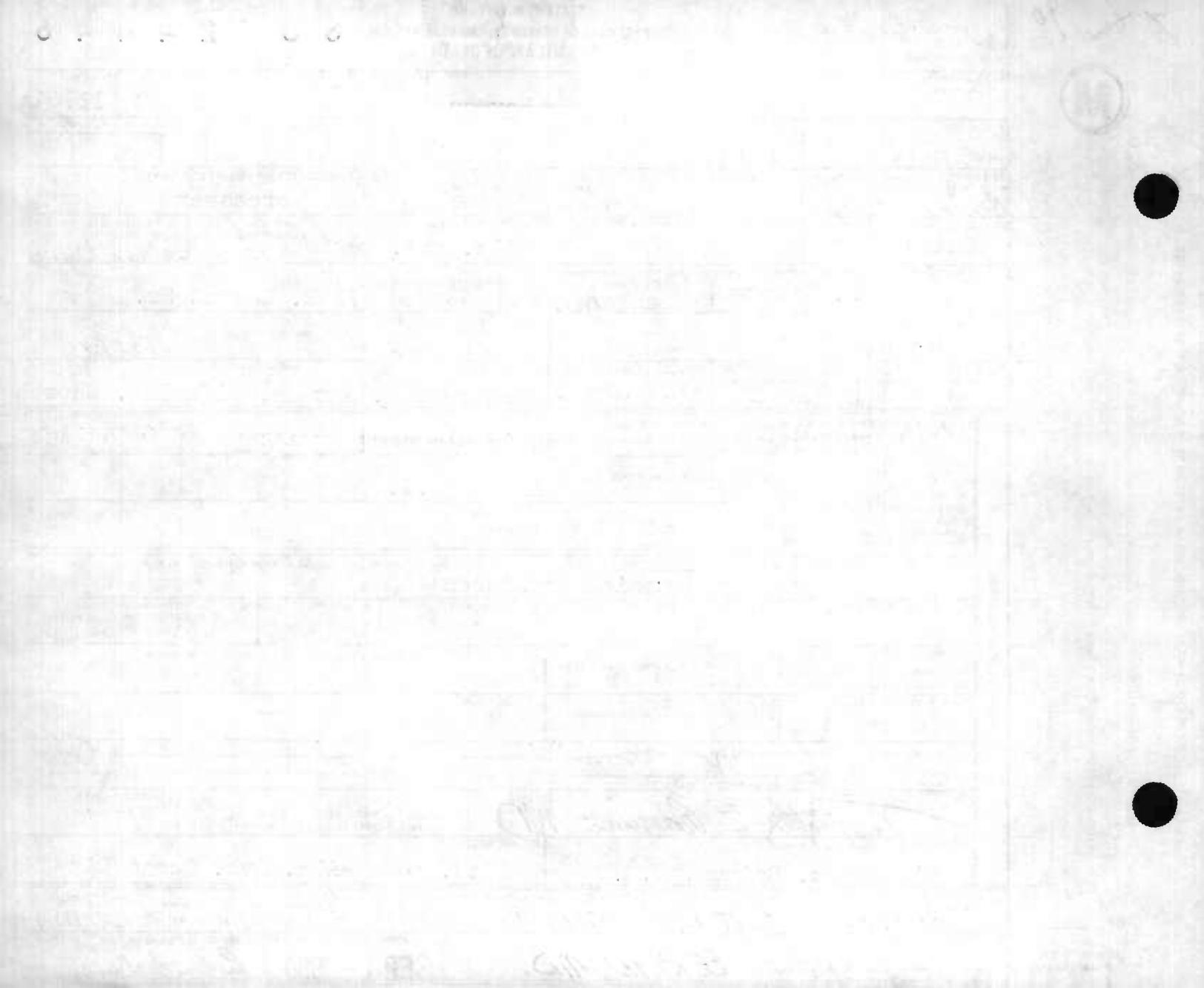
1. DECEASED NAME [TYPE OR PRINT]			NANNIE Gibbs FISHER			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE [IN YEARS LAST BIRTHDAY]			7. UNDER 1 YEAR	IF UNDER 24 HRS			
Female	Caucasian	MONTH DAY YEAR	92			MONTHS DAYS	YEARS	HOURS	MIN	
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Berlin	U.S.A.				Worcester					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Berlin	Berlin Nursing Home			Housewife			Home			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md.	Worcester	Berlin				U.S. RT. 50, RT. 2, Box 584				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST		
John	J.		Gibbs, Sr.	Sarah			-	Powell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No	220-16-9913			John T. Fisher, RT. 2, Box 585 Berlin, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROBABLE INTRABDOMINAL SPONTANEOUS HEMORRHAGE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1844 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC CARCINOMA OF THE VULVA</u>										1 YR.
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>CONGESTIVE HEART FAILURE</u>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____						
22a. I certify that (this hospital) attended the deceased from <u>7/12</u> 19 <u>80</u> to <u>9/13</u> 19 <u>80</u> , that (we) last saw the deceased alive on <u>7/12</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.										
23. MEDICAL CERTIFICATION 23a. SIGNATURE <u>Paul A. Scott</u>										23c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
23b. DATE SIGNED <u>9/15/80</u>										23d. DATE SIGNED <u>9/15/80</u>
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			22g. ADDRESS				
PAUL A. SCOTT, MD.			24 BROAD ST. BERLIN, MD.			24 BROAD ST. BERLIN, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		
Burial		9/16/80	Evergreen Cem.			Berlin		Worcester		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE DECD. BY FUNERAL DIRECTOR		25b. DATE DECD. BY CEMETERY			
Anna A. Burk		108 Williams St Berlin Md.			SEP 18 1980		Worcester, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 24446											
												REG. NO.											
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			George			D.						Harmon			9			10	80	11:44a			
3 SEX			4 RACE			5 DATE OF BIRTH			MONTH			DAY			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Male			White			8 23 1896			8			23			84			YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED			NEVER MARRIED			9 BALTIMORE CITY OR COUNTY OF DEATH								
Joseph Carolina			USA			X			WIDOWED			DIVORCED			Worcester			MD.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Ocean City			at home 2801 Phila. ave.			retired			Pear			Lehigh Univ.											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS														
PA N. Hampton			Bethlehem			YES X			NO			72 E. Church St.											
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME																				
FIRST JOSEPH			MIDDLE C			LAST HARMON			FIRST CYNTHIA			MIDDLE			LAST PETTY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS														
YES			WWI 721-10-9785A			Gertrude M. Harmon, Wife			72E. Church St.														
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY												1 immediate											
IMMEDIATE CAUSE (a)												Cardiopulmonary arrest											
410 -																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD- M. I.											
{												DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
pneumonia, Parkinson																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from 9/8/80 to 9/10, 1980, that (1) (we) last saw the deceased alive on 9/8/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.												22c. DATE SIGNED 9/10/80											
22b. SIGNATURE Timothy E. Bainum MD			22d. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS														
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Timothy E. Bainum, M.D.			22g. ADDRESS 16th. and Phila. Ave. Ocean City, Md																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT 13, 80			23c. NAME OF CEMETERY OR CREMATORIAL NISKY HILL CEMETERY			23d. LOCATION CITY/TOWN BETHLEHEM			COUNTY STATE NORTHAMPTON PA											
24. FUNERAL DIRECTOR NAME John Ullrich - BERKIN, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 15 1980			25b. REGISTRAR'S SIGNATURE Timothy E. Bainum														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 24447								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Richard Harold Hayward, Sr.												Sept. 2 1980								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
Male			Caucasian			Month Day Year			83			MONTHS DAYS			HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Del.			U.S.A.									Worcester								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Berlin			105 West Street			Farmer			Agriculture											
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
Md.			Worcester			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			105 West Street											
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			LAST											
Samuel			J. Hayward			Sarah Elizabeth			Harris											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No			218-12-1374			Marion E. Chambers			Ocean City											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)																				
PART 1. DEATH WAS CAUSED BY:																				
IMMEDIATE CAUSE (a) <u>AN-41A</u>																				
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIR. INSUFFICIENCY</u>								
												DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF BOTH LUNGS</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY								
22a. I certify that (I) (this hospital) attended the deceased from <u>July 26</u> , 19 <u>73</u> , to <u>SEP. 2</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>SEP. 2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <u>Alfredo B. Fernandez</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-4-80											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALFREDO B. FERNANDEZ</u>			22e. ADDRESS <u>DEAN CITY BLVD. BERLIN 172-21811</u>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>9/5/80</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Buckingham Cem.</u>			23d. LOCATION CITY OR TOWN <u>Berlin</u>			23e. COUNTY <u>Wor.</u>								
24. FUNERAL DIRECTOR NAME <u>Anna A. Bentz</u>			ADDRESS <u>1088 Williams St. Berlin, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 8 1980</u>			25b. REGISTRAR'S SIGNATURE <u>harry mckay</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 24448
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			0 9 6 80			9 10 AM			
Thomas H. Hudson												
3. SEX male			4. RACE W			5. DATE OF BIRTH MONTH 7 DAY 16 YEAR 97			6. AGE (IN YEARS LAST BIRTHDAY) 83 yrs.			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Berlin, md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Worchester			
10. CITY OR TOWN OF DEATH Snow Hill			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harrison House			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer			12b. KIND OF BUSINESS OR INDUSTRY Agriculture			
13a. STATE Md.			13b. COUNTY Worchester			13c. CITY OR TOWN Brews			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST Ezekiel			MIDDLE Hudson			15. MOTHER'S MAIDEN NAME Ida			16. STREET ADDRESS Rt. N. Box 295			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-20-5495			17. INFORMANT Mrs Frances D. Hudson R#4, Box 295 Berlin Md			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for Part 1, Item 18, and Part 2, Item 21d.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b), DUE TO, OR AS A CONSEQUENCE OF (c),												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) saw the deceased alive on 9/4 19 80			21f. LOCATION STREET CITY OR TOWN CITY OR TOWN COUNTY COUNTY STATE STATE						
22a. I certify that (I) (has/have) attended the deceased from 8/8 19 80 to 9/6 19 80, that (I) (has/have) last seen the deceased alive on 9/4 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Thomas H. Jones, M.D.			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/6/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas H. Jones, M.D.			22e. ADDRESS 112 PEARL ST, SAWHILL, MD. 21863									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/9/80			23c. NAME OF CEMETERY OR CREMATORIAL Taylorsville Cemetery			23d. LOCATION CITY OR TOWN Berlin Wor. Md.			
24. FUNERAL DIRECTOR NAME Anna A. Burbage 108 Williams St. Berlin Md.			25a. DATE REC'D. BY REGISTRAR SEP 15 1980			25b. REGISTRAR'S SIGNATURE Lester Johnson						

1962-01-14 200000

M

1962-01-14 200000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 24449				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Sosie Pritchard Ingram						9 25 80					9 55	M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Female		White		Aug 30, 1893		87			YRS		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		USA				Worcester County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Berlin		Berlin Nursing Home		Seamstress										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS				
13a. STATE MD		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1, Box 573					
14. FATHER'S NAME FIRST Cyrus		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Elizabeth			MIDDLE	LAST	Donovan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
No		215-03-1863		Kenneth Pritchard, Easton, MD 21601			Rt. 1, Box 573							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE				
2765 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any														
(b) ADVANCED AGE														
(c) DEHYDRATION														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) URINARY TRACT INFECTION														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
—		—		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			—							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 7/4		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/25 1980 to 7/4 1980, and that (I) (we) last saw the deceased alive on 9/25 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		22b. SIGNATURE PAUL A. SCOTT, MD.		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/26/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. SCOTT, MD.		22e. ADDRESS 24 BROAD ST. BERLIN, MD. 21811												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-28-80		23c. NAME OF CEMETERY OR CREMATORIAL East New Market			23d. LOCATION CITY OR TOWN East New Market, Dorchester MD			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Zeller Funeral Home, East New Market, MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 7 1980			25b. REGISTRAR'S SIGNATURE HARRY KELLOGG							
DHMH-16 25M (VRA 15, 4) 1/79														



000 8136

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR RECORDS. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24450				
1. DECEASED NAME (TYPE OR PRINT)			FIRST HERMAN			MIDDLE ALBERT			LAST MITCHELL			2a. DATE KNOWN OF EST. DEATH MATE	MONTH 9	DAY 20	YEAR 1980	2b. HOUR 6 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.			IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD	MONTH 9	DAY 20	YEAR 1980	2d. HOUR 8 P.M.		
MALE	WHITE	2 6 1917	63 81	MONTHS	0	0	0	0	0	0	0	0	0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. MARRIED NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH					
DELAWARE		USA			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			WORCESTER MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
BISHOP		LINE Road			LABORER			FARMING								
13a. STATE DELAWARE		13c. CITY OR TOWN SUSSEX			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS R.D. 1, BOX 184 A								
14. FATHER'S NAME CHARLES		15. MOTHER'S MAIDEN NAME MITCHELL MINNIE			16. SOCIAL SECURITY NO. 221-18-2947			17. INFORMANT SARAH MITCHELL, DAGSBORO, DEL.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4392 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Acute Congestive Heart Failure Arteriosclerotic Cardiovascular Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>														
ACTUAL SIGNATURE Herman J. Mitchell		TITLE (SPECIFY) M.D.			D. MITCHELL			MEDICAL EXAMINER			DATE SIGNED 9/20/80					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS														
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9-26-80			23c. NAME OF CEMETERY OR CREMATORIUM DAGSBORO MEMORIAL CEM.			23d. LOCATION CITY OR TOWN DAGSBORO SUSSEX DELAWARE								
24. FUNERAL DIRECTOR Herman J. Mitchell		ADDRESS FRANKFORD, DEL.			25a. DECEASED BY REMOVAL SEP 20 1980			25b. REGISTERED BY Herman J. Mitchell								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 4 4 5 1

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED				MONTH	DAY	YEAR	2b. HOUR					
EDWARD RAYNE POWELL							<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	3	1980	12P M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD							
Male Caucasian		Nov. 5 1918 61				YRS.		MONTHS		DAYS HOURS MIN		9 3 1980 2P M							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH													
Md.		U.S.A.		WORCESTER		Newark													
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Old US Route 13												Field Surveying				Soil Conservation			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME							
Md				Worcester		Newark		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PO Box 51 Old US. Rt #113		Willard — Powell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		15. MOTHER'S MAIDEN NAME				LAST							
No.				217-36-5034		Margaret G. Pennewell		Martha Lizzie — Rayne				202 Broads.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												ADDRESS							
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c) DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D.				D�p. MEDICAL EXAMINER				DATE SIGNED							
EXAMINER'S NAME (TYPE OR PRINT)				THOMAS L. JONES, M.D.				ADDRESS				112 PEARL ST, SNOW HILL, MD. 21863							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL LOCATION				23d. DATE REC'D. BY REGISTRAR		23e. COUNTY				STATE			
Burial 9/6/80				Mt Pleasant Church Cemetery, Willards, W. Va.		W. Va.				SEP - 9 1980		Md.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25b. REGISTRAR'S SIGNATURE											
Anna A. Butcher 108 Williams St. Berlin, Md.																			

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 0 2 4 4 5 2

1a. DECEASED NAME (TYPE OR PRINT)	FIRST George	MIDDLE Powell	LAST	2a. DATE OF DEATH MONTH MARCH	DAY 22	YEAR 1893	2b. HOUR 6:10 pm
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH MARCH	DAY 22	YEAR 1893	6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED	9. NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER CO.			
10. CITY OR TOWN OF DEATH POCOMOKE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HARTLEY HALL NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.	13b. COUNTY WICOMICO	13c. CITY OR TOWN SALISBURY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 508 WINDER ST.			
14. FATHER'S NAME FIRST JAMES POWELL	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST LAURA ELLIS	MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 220-10-8187	17. INFORMANT MRS MARY WIDDOWSON	ADDRESS SALISBURY, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cerebral Vascular Accident							
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardio Vascular Disease							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from show the deceased alive on 09/25/1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						09/25/1980	09/25/1980
22b. SIGNATURE J. G. Santiano, MD						DEGREE	22c. DATE SIGNED 9-26-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. G. Santiano, MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. ADDRESS 100 8th. Street, Pocomoke City, Md. 21851							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/29/80	23c. NAME OF CEMETERY OR CREMATORIAL PARSONS CEMETERY	23d. LOCATION CITY OR TOWN SALISBURY	23e. COUNTY	23f. STATE		
24. FUNERAL DIRECTOR NAME WILSON FUNERAL HOME	ADDRESS SALISBURY, MD.	25a. DATE REC'D. BY REGISTRAR OCT 1 1980			25b. REGISTRAR'S SIGNATURE Robert McCreary		

M

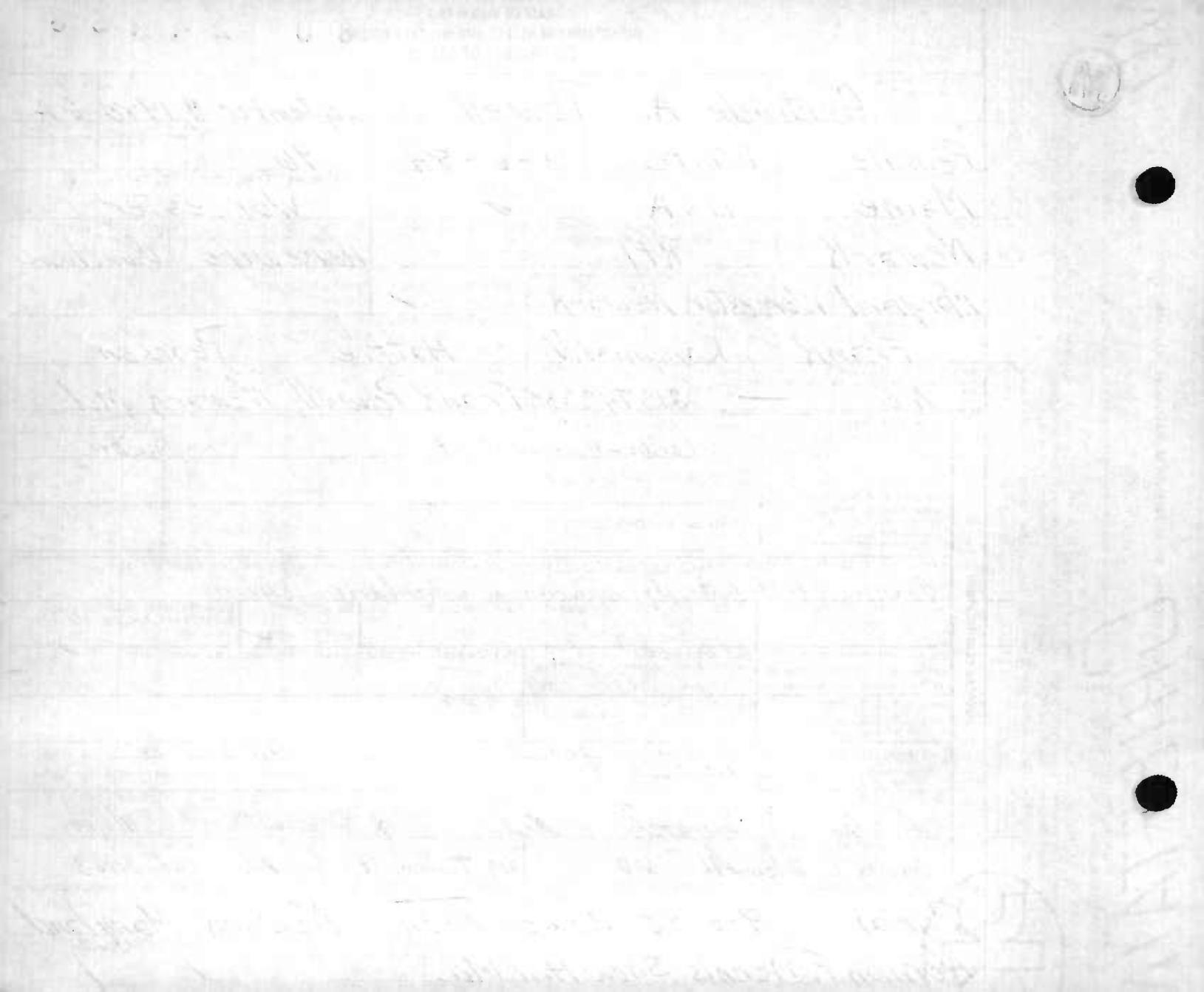
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0	2	4	4	5	3
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Gertrude A. Powell						September 4 1980						6 A M			
3. SEX			4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			White	MONTH	DAY	YEAR	96			MONTHS	YEARS	MONTHS	YEARS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maine			USA						Worcester						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Newark			RTI			Housewife			Our Home						
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Worcester												
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
Frank					Langmaid	Hattie					Pearson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO			—			213 743 330			Frank Powell, Newark, Md.			See Mrs.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Arrest</u>															
4275 DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c).															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Anemia, Cerebral atrophy, inanition, generalized arteriosclerosis</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 80 to <u>Sept 3</u> 19 80, that (I) (we) lost saw the deceased alive on <u>Sept 3</u> 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
Dorothy C. Holzworth			A.D.									9/4/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			309 Timmons St., Snow Hill, Md. 21863									
Dorothy C. Holzworth MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY, TOWN			23e. COUNTY			
Burial			9-6-80			Bowen Meth.			Newark			Maryland			
24. FUNERAL DIRECTOR NAME			ADDRESS			24e. DATE REC'D. BY FUNERAL DIRECTOR			24f. RECD. BY FUNERAL DIRECTOR			24g. RECD. BY FUNERAL DIRECTOR			
Norman F. Dennis, Snow Hill, Md.						SLT - 9 1980									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 4 4 5 4

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	12	Day	12	Year	80	2b. HOUR 7 A.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH 4/23/1896			6. AGE (In years last birthday) 84			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED X		9. COUNTY OF DEATH Worcester		YRS.			
10. CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 310 S. Main St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Berlin		13d. INSIDE CITY LIMITS? YES X NO		13e. STREET AND NUMBER 310 S. Main St.			
14. FATHER'S NAME Charles		First	Middle	Last	15. MOTHER'S MAIDEN NAME H. Holland		First	Middle	Last	Mary - Ennis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. No		17. INFORMANT 213-05-0869 Mrs Anna T. Esham			Address 1 Washington St. Berlin, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROTIC VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 2/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR. CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <input checked="" type="checkbox"/> Month Day Year P.M. <input type="checkbox"/> 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul A. Scott, MD		22c. DEGREE ATTENDING PHYS.			MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 9/15/80				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 24 BROAD ST. BERLIN, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/14/80		23c. NAME OF CEMETERY OR CREMATORIUM St Paul's Episcopal Church			23d. LOCATION (City or Town) Berlin		(County) Wor.		(State) Md.
24. FUNERAL DIRECTOR Anna A. Butler 108 Williams St. Berlin, Md.		ADDRESS			25a. RECD BY REGISTRAR DATE SEP 18 1980		25b. REGISTRAR'S SIGNATURE Lily McElroy				

THE HERTFORDSHIRE

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8024455			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
EDWARD WASHINGTON YOUNG, JR.						September 11, 1980							
3. SEX			RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
male			white	July 27, 1916			64 YRS.			MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			USA						Worcester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Pocomoke			902 Cedar Street			retired Postmaster							
13a. STATE Maryland			13b. COUNTY Worcester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 902 Cedar Street				
14. FATHER'S NAME Edward Washington Young, Sr.			15. MOTHER'S MAIDEN NAME Mary									LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. no 220-05-3133			17. INFORMANT ADDRESS 902 Cedar Street Thelma Young Pocomoke City, Md.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic carcinoma of spinal cord													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Paraplegia resulting from metastatic carcinoma of spinal cord													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE N. E. Sartorius, Jr. M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/15/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. E. Sartorius, Jr.			22e. ADDRESS 114 Market St. Pocomoke, Md. 21851										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/14/80			23c. NAME OF CEMETERY OR CREMATORIAL First Baptist Cem.			23d. LOCATION CITY OR TOWN Pocomoke			COUNTY Worcester	STATE Md.
24. FUNERAL DIRECTOR NAME Scott S. Nelson			ADDRESS Pocomoke City, Md.			25a. DATE RECD. BY REGISTRAR SEP 19 1980			25b. REGISTRATION SIGNATURE S. S. Nelson				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Item 21a & 21f G548 10/14/80 24 4 5 6			
1. DECEASED NAME (TYPE OR PRINT)										REG. NO.			
Shawn Michael Michael Young													
3. SEX	4. RACE	5. BIRTH DATE	6. AGE IN YEARS (LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. IF UNDER 24 HRS. HOURS	10. IF UNDER 24 HRS. MIN.	2a. DATE KNOWN OF DEATH ESTI- MATED	2b. MONTH	2b. DAY	2b. YEAR	2d. HOUR	
Male	White	4-28-55	25 yrs.					9 21	1980	125			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED		2c. DATE PRONOUNCED DEAD		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		US				MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 21		15 WORCESTER			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Berlin		Assateague Island N.P.				Waterman				Fishing			
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 1 Box 399B					
14. FATHER'S NAME Joseph I. McNichol		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Ann H. Young nee Holland							
16a. WAR DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN)		16b. SOCIAL SECURITY NO. 212-66-0835				17. INFORMANT Ann H. Young Berlin, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9108 IMMEDIATE CAUSE (a) <u>Preservency</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) no boat involved				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN Assateague Island 1/2 mile S. of range				COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion station death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Thomas H. Jones, M.D.</u> TITLE <u>Deputy</u> MEDICAL EXAMINER												DATE SIGNED <u>9/21/80</u>	
23a. EXAMINER'S NAME (TYPE OR PRINT)		23b. ADDRESS 112 Peale St., Snow Hill, Md. 21863				23c. NAME OF CEMETERY OR CREMATORIAL SOCIETY				23d. LOCATION CITY OR TOWN Belvoir, Worcester, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-24-80				23c. NAME OF CEMETERY OR CREMATORIAL SOCIETY Evergreen Cemetery				23d. LOCATION CITY OR TOWN Belvoir, Worcester, Md.			
24. FUNERAL DIRECTOR Ulrich Funeral Home		ADDRESS Berlin, Md.				25. DEATH CERTIFIED BY RECORD							
BP													
DHMH - 17 (VR A15 ME (5)) 15M 7/76													

